7: Furnivall G-4, 5 (no date) 1948 AL1 Southeast Asia AL1

Pestiferous slums compel attention in the larger towns, but conditions may be worse in the smaller towns up-country where they escape notice; even the villages often suffer from congestion. Food is less abundant, because cultivation for export reduces the area under subsistence crops, and the greater pressure on this smaller area diminishes the outturn; the demands of western enterprise for labour have a similar effect. Often the people take to cheaper or to more palatable but less nutritious food; thus groundnut oil replaces sesamum oil, cassava replaces rice, polished rice spreads beri-beri; sometimes the food is adulterated with imported products as when for some years large quantities of mineral oil were imported into Burma to mix with native vegetable oils. The natural effect of the economic forces released in the course of development is to lower the standard of health.[1]

Again, with man, as with crops and cattle, there is an intimate link between material development and infection. The improvement of communications and the mass migration of labourers spread old diseases and bring in new diseases. In Africa 'diseases have been introduced to which the African was formerly a stranger, and fresh strains of parasites cause attacks to which he was formerly immune; further, Africans now contract diseases common to temperate zones, and it is possible that the intensity of these is increased owing to the lack of acquired immunity'. The spread of sleeping sickness 'must in many cases be associated with the opening of new communications and the development of trading facilities'. The conditions under which labour is employed foster venereal disease, which in modern Africa seems to have an incidence ranging from 50 to 90 %.[2]

For various reasons also native medical skill deteriorates. The patronage of native rulers encourages the most successful physicians, and helps to maintain traditions, in Burma reminiscent of the Hippocratic oath, that make for professional self-respect. Under western rule the native doctors lose their best and most remunerative clients. Moreover the herbs, formerly gathered in the fields, come to be purchased in the market, and are liable to adulteration, so that the practitioner no longer knows what he prescribes. This applies also to modern substitutes for native drugs, such as cheap brands of quinine tabloids which, if they contain any quinine, are of little use except as marbles owing to the thickness of the coating; prac-

[1] *ISC*, I, 21; Mills, p. 321; *RAB*, 1915–16, p. 30; 1918–19, p. 41.
[2] *African Survey*, pp. 1129, 1144–6, 1199.

7: Furnivall G-4, 5 (no date) 1948 ALI Southeast Asia ALI

titioners and patients do not know the difference and buy the cheapest.[1]

These probably are among the chief reasons why 'the systems of oriental medicine have fallen into decay'. The task of improving the standard of health in the tropics is aggravated by the fact that western medical science usually reaches the people as one aspect of economic penetration, and must first be applied towards repairing and preventing the mischief naturally consequent on the process of development. A solution of the problem has been attempted along two lines: the provision of medical assistance; and the introduction of modern hygiene. It is important to notice the essential difference between these alternatives. Medical assistance aims to promote *individual* welfare, and ordinarily requires the voluntary co-operation of the patient; hygiene aims to promote *social* welfare, and necessarily involves a certain measure of compulsion.

2. MEDICINE

Ordinarily the introduction of western medicine in the tropics originates in the needs of Europeans. From very early days the East India Company arranged with the Apothecaries Company for the supply of barber-surgeons to their ships and settlements. In Africa likewise the various administrations at first confined the provision of medical services to the needs of their own establishments. But administrative establishments are partly native, and non-officials in commerce and industry require medical attention. In Burma the earliest members of the general public to receive the benefits of western medical skill were the convicts in jail, and the expansion of medical services in the interior has been closely bound up with the growth of crime. It is only natural that generally throughout the tropics the provision of medical assistance has developed with the economic demand for doctors, and has been organized so as to cost no more than necessary.

But the spread of western medicine in the tropics has not been due solely to the growing demand for doctors; it has been due in part to the demand for patients. Medical missionaries look for patients. It is true that missionary organizations need doctors to preserve the lives of missionaries. But they have also recognized in western medicine an instrument for extending their influence among the people. To deliver their message they must find some method of

[1] *RPI* (India), 1897–1902, p. 245; *CISM*, pp. 13, 15, 23.